

AFFIRMATION (required for all grant submissions)**Office of Emergency Medical Services, 1041 Technology Park Drive, Glen Allen, VA 23059**

The Authorized Agent and Financial Officer, whose names and signatures appear below, have been designated by the agency/organization to complete and submit a grant request on its behalf. The agency/organization agrees to comply with the Rules and Regulations Governing Financial Assistance for Emergency Medical Services for Rescue Squad Assistance Fund requests. In addition, the Authorized Agent and Financial Officer attest to the agency's or organization's ability to provide the matching funds (if required) to complete the purchase of the requested item(s), should they be awarded state funds. The Authorized Agent and Financial Officer are aware that EMS vehicles and equipment purchased with state monies must be purchased without any financial liens and without the item being used as collateral to secure a loan of any kind. The Authorized Agent and Financial Officer, by signing below, attest to the fact that the Agency(s) that are affected by the possible outcome of this grant request, have been notified and agree to its submission. RSAF Requests: The Authorized Agent and Financial Officer, by signing below attest that to the best of his/her knowledge, the information contained herein with regard to the agency's financial condition is true, accurate and correctly reflects the financial condition of the agency/organization. ***The OMD signature is required all for grants. This form must be received by the grant deadline date with original signatures from the Authorized Agent, Fiscal Officer and Operational Medical Director (OMD).***

Request for Federal/Employer Identification Number (required)

Business Name (as shown on your income tax return)

Business name, if different from above (Doing Business As (DBA))

Address (number, street, and/or suite no. per FIN)

City, State, and Zip code

Federal Identification Number

OEMS USE ONLY:

	Authorized Agent	Financial Officer	Operational Medical Director (OMD)
Name:			
Title:			
Phone:			
E-Mail:			
Signature:			

Point of Contact for Grant Management:**Name:****Agency:****Phone:****Email:****OPTIONAL: City/County Representative**

City/County representative shown below has been informed of the _____ (insert agency name) _____ request for grant funds.

Printed Name

Title

Brief Project Description: (IF NOT COMPLETE, APPLICATION IS DISQUALIFIED)**Project/Equipment Sustainability: (IF NOT COMPLETE, APPLICATION IS DISQUALIFIED)**

(How does your agency propose to sustain this project/equipment after funding is complete?)